

Psychiatric Briefs

Psychodermatology: The Mind and Skin Connection

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Psychodermatologic disorders, which involve interactions between the skin and the mind, can be classified into 3 broad categories: psychophysiologic disorders, primary psychiatric disorders with a dermatologic component, and secondary psychiatric disorders stemming from skin disfigurement. Psychophysiologic disorders are skin conditions that are often preceded or worsened by emotional stress; such conditions include acne, psoriasis, and urticaria (hives). Treatment of psychophysiologic disorders should target both the skin condition itself and the underlying psychological, social, and/or occupational stress. Primary psychiatric disorders that have a dermatologic component include delusions of parasitosis, in which patients believe their bodies are infested by an organism; disorders (usually depressive, anxiety, or obsessive-compulsive) involving self-inflicted skin damage such as neurotic excoriations (making scratch marks on the skin using the fingernails) and factitial dermatitis (damaging the skin with external agents such as sharp instruments or chemicals); and trichotillomania, in which a person pulls out his or her own hair. Treatment of these conditions is determined by the nature of the underlying disorder (e.g., delusions of parasitosis can be treated with the antipsychotic doxepin; the underlying depression involved in self-inflicted skin damage can be treated with antidepressants). Finally, secondary psychiatric disorders, including depression and social phobia, can result from disfiguring skin conditions and should receive appropriate treatment. Family physicians are in an ideal position to help individuals with psychodermatologic disorders since such individuals may be reluctant to incur the stigma attached to psychiatric treatment and family physicians are familiar with the use of psychotropic medications.

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Bupropion Sustained Release as a Smoking Cessation Treatment in Remitted Depressed Patients Maintained on Treatment With Selective Serotonin Reuptake Inhibitor Antidepressants

Chengappa KNR, Kambhampati RK, Perkins K, et al.

Background: Patients with depressive disorders smoke tobacco more often than the population at large and find quitting more difficult. Furthermore, when they quit smoking, they are more likely to suffer a relapse of depression. We evaluated the addition of bupropion sustained release (SR) for smoking cessation among patients with a history of depressive disorders being maintained in a euthymic state with selective serotonin reuptake

inhibitor (SSRI) antidepressants. **Method:** Twenty-five adults with DSM-IV major depressive disorder or depressive disorder NOS currently receiving SSRI maintenance treatment and smoking ≥ 15 cigarettes per day participated in the 9-week study. Bupropion SR, 150 mg/day, was added to SSRI treatment and increased to 300 mg/day. Subjects were counseled on smoking cessation measures and chose a target quit date 2 or 4 weeks after the initiation of bupropion SR. Self-reported smoking status, expired carbon monoxide (CO) measurements, Hamilton Rating Scales for Depression and Anxiety scores, and weight were measured at each visit. Subjects were abstinent if they reported not smoking during the prior 7 days, confirmed with an expired-air CO value of ≤ 10 ppm. **Results:** Eight (32%) of 25 subjects were abstinent after 9 weeks. At 3-month follow-up, 3 subjects remained abstinent, 3 relapsed, and 2 were lost to follow-up. Eleven subjects (44%) were non-responders, and 6 (24%) dropped out prior to 3 weeks of treatment due to side effects (N = 3) or were lost to follow-up (N = 3). Mean weight gain was approximately 0.5 lb (0.2 kg) for those completing 9 weeks of bupropion SR treatment. During the 9-week study and the 3-month follow-up, there was no evidence of emergent depression in any subject. Four subjects (16%) spontaneously reported an improvement in SSRI-associated sexual dysfunction. **Conclusion:** These open data suggest modest effectiveness for and the safety of bupropion SR as a smoking cessation agent in individuals with depression maintained on treatment with SSRIs. Minimal weight gain, lack of emergent depressive episodes, and improvement of SSRI-associated sexual dysfunction are added advantages.

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Cost-Effectiveness of a Collaborative Care Program for Primary Care Patients With Persistent Depression

Simon GE, Katon WJ, VonKorff M, et al.

Objective: Compared with usual care, collaborative care programs for primary care patients with depression are associated with superior illness outcomes but also with higher costs. This study examined the cost-effectiveness of a stepped collaborative care treatment program for patients with depressive symptoms that had persisted after 6 to 8 weeks of treatment by primary care physicians. **Method:** Patients from 3 large primary care clinics in Washington State were interviewed by telephone 6 to 8 weeks after being prescribed an antidepressant; those having persistent major depression or significant residual depressive symptoms were randomly assigned either to continue treatment as usual or to begin a stepped collaborative care program that included the following interventions: education about the effective management of depression, 2 to 4 visits with a liai-

son psychiatrist working in the primary care clinic, adjustment of antidepressant pharmacotherapy based on an algorithm, referral to psychosocial treatment or community resources as needed, and monitoring of adherence to medication regimen. Blinded telephone assessments were made at 1, 3, and 6 months to evaluate clinical outcomes. Health plan claims and accounting data were examined to determine utilization and costs of health services. **Results:** Patients in the collaborative care program experienced more depression-free days (mean difference = 16.7 days) than patients receiving usual care. The mean incremental cost of depression treatment was \$357 in the collaborative care program, with an incremental cost-effectiveness of \$21.44 per depression-free day. The additional costs of the collaborative care program stemmed from costs associated with antidepressant prescriptions and outpatient visits; collaborative care was not associated with decreased utilization of other health resources. **Conclusions:** As in other randomized studies, collaborative care of depressed patients in primary care led to both improved effectiveness of treatment and higher treatment costs. The findings of this study suggest, however, that increased spending on treatment of depression is a prudent investment when seen in the context of other preventive and therapeutic medical interventions.

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Effective Mood Stabilization With a Chelated Mineral Supplement: An Open-Label Trial in Bipolar Disorder

Kaplan BJ, Simpson SA, Ferre RC, et al.

Background: To determine in open trials the therapeutic benefit of a nutritional supplement for bipolar disorder. **Method:** The sample consisted of 11 patients with DSM-IV–diagnosed bipolar disorder aged 19 to 46 years, who were taking a mean of 2.7 psychotropic medications each at study entry. Three additional patients dropped out prematurely. The intervention is a broad-based nutritional supplement of dietary nutrients, primarily chelated trace minerals and vitamins, administered in high doses. At study entry and periodically thereafter, patients were assessed with the Hamilton Rating Scale for Depression (HAM-D), the Brief Psychiatric Rating Scale (BPRS), and the Young Mania Rating Scale (YMRS). **Results:** For those who completed the minimum 6-month open trial, symptom reduction ranged from 55% to 66% on the outcome measures; need for psychotropic medications decreased by more than 50%. Paired *t* tests revealed treatment benefit on all measures for patients completing the trial: HAM-D mean score at entry = 19.0, mean score at last visit = 5.4, *t* = 5.59, *df* = 9, *p* < .01; BPRS mean score at entry = 35.3, mean score at last visit = 7.4, *t* = 2.57, *df* = 9, *p* < .05; YMRS mean score at entry = 15.1, mean score at last visit = 6.0, *t* = 4.11, *df* = 9, *p* < .01. The effect size for the intervention was large (> .80) for each measure. The number of psychotropic medications decreased significantly to a mean \pm SD of 1.0 ± 1.1 (*t* = 3.54, *df* = 10, *p* < .01). In some cases, the supplement replaced psychotropic medications and the patients remained well. The only reported side effect (i.e., nausea) was infrequent, minor, and transitory. **Conclusion:** Some cases of bipolar illness

may be ameliorated by nutritional supplementation. A randomized, placebo-controlled trial in adults with bipolar I disorder is currently underway, as well as open trials in children.

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The Child With ADHD: Using the AAP Clinical Practice Guideline

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In 2000, the American Academy of Pediatrics (AAP) published the Clinical Practice Guideline on the Diagnosis and Evaluation of the Child With Attention-Deficit/Hyperactivity Disorder (ADHD), a set of evidence-based recommendations intended for use by primary care physicians. This article summarizes the 6 recommendations in the guideline: (1) primary care providers should initiate evaluation of ADHD in children 6 to 12 years of age who display inattention, hyperactivity, impulsivity, underachievement in school work, or behavior problems; (2) DSM-IV criteria must be met for a diagnosis of ADHD; (3) information (including evidence regarding core ADHD symptoms, age at onset, duration of symptoms, and degree of functional impairment) should be obtained directly from parents or other caregivers; (4) that information should then be corroborated by a child's classroom teacher or another school professional; (5) assessment for coexisting mental disorders should accompany evaluation of children with ADHD; and (6) although other diagnostic tests can help identify coexisting conditions, they should not be used to establish a diagnosis of ADHD. The article calls for future research on the validity of ADHD subtypes, the reliability and validity of current diagnostic methods for the disorder (including parent and teacher rating scales), and the effectiveness of current evaluative practices among primary care physicians. In addition, the article lists DSM-IV criteria for ADHD, includes an algorithm to aid in the diagnosis and evaluation of ADHD, and provides a patient information handout on the disorder.

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Combining Psychotherapy and Antidepressants in the Treatment of Depression

de Jonghe F, Kool S, van Aalst G, et al.

Objective: The conviction shared by many clinicians that combining psychotherapy with pharmacotherapy in treating depression is more efficacious than either treatment alone has not been confirmed empirically. This study compared the efficacy of antidepressant pharmacotherapy with that of combined antidepressant pharmacotherapy and psychotherapy ("combined therapy") in depressed patients. **Method:** Consecutive ambulatory outpatients admitted to a clinic in Amsterdam, the Netherlands (*N* = 167), who had DSM-III-R major depression and had a 17-item Hamilton Rating Scale for Depression (HAM-D) score ≥ 14 were randomly assigned to 6 months of treatment with antidepressants alone (*N* = 84) or combined therapy (*N* = 83). Antidepressant treatment began with fluoxetine, but could,

in cases of intolerance or inefficacy, be switched to amitriptyline and then to moclobemide. Combined treatment followed the same protocol for pharmacotherapy and also comprised 16 sessions of Short Psychodynamic Supportive Therapy. Efficacy was measured after 8, 16, and 24 weeks of treatment using the HAM-D, the Clinical Global Impressions-Severity of Illness (CGI-S) and -Improvement (CGI-I) scales, the Symptom Checklist-90 (SCL-90), and the Quality of Life Depression Scale (QLDS). Assessments were made using data from 3 patient samples: intent-to-treat (ITT; all patients who entered the study), per protocol (PP; all patients who began treatment in 1 of the 2 treatment groups), and observed cases (OC; patients for whom data were gathered at all assessment points). **Results:** Of the 167 patients who entered the study, 129 started treatment (pharmacotherapy, $N = 57$; combined therapy, $N = 72$). Significantly more patients in the pharmacotherapy group (40%) than in the combined therapy group (22%) stopped taking medication during the course of the study ($p < .026$). Patients receiving combined therapy achieved remission more quickly than patients receiving pharmacotherapy alone as defined by a HAM-D score ≤ 7 ($p \leq .05$ for ITT, PP, and OC groups). Overall, 40.7% of patients receiving pharmacotherapy alone and 59.2% of patients receiving combined therapy were treated successfully, as defined by HAM-D, CGI-S and CGI-I, SCL-90, and QLDS outcomes. **Conclusion:** Combined therapy led to fewer dropouts and was more efficacious than pharmacotherapy alone in treating ambulatory patients with major depression and should be the preferred treatment for those patients.

(*J Affect Disord* 2001;64:217-229)

Comorbidity of Axis I Disorders in Patients With Traumatic Grief

Melhem NM, Rosales C, Karageorge J, et al.

Background: Traumatic grief has been found to be a distinct disorder from both depression and anxiety; however, there is no information in the literature regarding comorbidity of traumatic grief with other psychiatric disorders. **Method:** Twenty-three bereaved subjects who presented for treatment of traumatic grief symptomatology were included in this study. The Inventory of Complicated Grief (ICG) was used to confirm the presence of traumatic grief and assess its severity. In addition, the Structured Clinical Interview for DSM-IV was performed. **Results:** Most subjects met criteria for a current or lifetime Axis I diagnosis. Fifty-two percent ($N = 12$) met criteria for current major depressive disorder, and 30% ($N = 7$), for current posttraumatic stress

disorder (PTSD). ICG scores and functional impairment were higher among patients with more than one concurrent Axis I diagnosis. **Conclusion:** Comorbid major depressive disorder and PTSD may be prevalent in patients presenting for treatment of traumatic grief.

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Dimensional Perspective on the Recognition of Depressive Symptoms in Primary Care: The Hampshire Depression Project 3

Thompson C, Ostler K, Peveler RC, et al.

Background and Aims: The low reported detection rates of depression in primary care may be attributed to the use of categorical definitions of depression, which can oversimplify diagnosis by dichotomously separating patients into groups above and below a given threshold for depression and thus underestimate the effect of illness severity on recognition. This study explored the relationship between depressive severity and recognition of the illness and the effect of patient and practitioner characteristics on that relationship. **Method:** As part of the Hampshire (U.K.) Depression Project, researchers ascertained the presence or absence of depression in 18,414 primary care patients (drawn from 152 general practitioners) using the Hospital Anxiety and Depression (HAD) scale. The general practitioners, blinded to the HAD scale scores, rated depression in each patient on a dimensional scale from 0 (no depression) to 3 (moderate-to-severe clinically significant depressive illness). **Results:** A curvilinear relationship was found between depression severity and practitioners' ratings of depression. Although 64.7% cases of depression were missed by general practitioners under conventional analysis of number of cases missed, only 1 case of "probable" depression was missed in every 28.6 consultations using the dimensional approach. Patient anxiety levels and unemployment rates affected recognition of depression, although age, gender, and level of economic deprivation did not. **Conclusions:** Rates of recognition of depression among primary care practitioners may not be as poor as previously supposed. Because extensive efforts to educate general practitioners about depression may lead to an increase in false positive diagnoses of depression, educational and research programs should target those physicians who have difficulty recognizing depression and focus on providing better care to those patients who are recognized as having depression.

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